FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #13-100-9006
Northwest Community Hospital

Introduction

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Northwest Community Hospital. In November 2012, the HRA notified Northwest Community Hospital of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint accepted for investigation was that a patient was unjustly held in the emergency department. The rights of patients are protected by the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5/3-403).

According to its web-site, Northwest Community Hospital (NCH) is a 496-bed hospital with nationally recognized physicians and state-of-the-art technology. NCH combines compassionate care with a healing environment and the latest in medical facilities, plus a full range of medical specialists, including inpatient and outpatient services.

Methodology

To pursue this investigation, the HRA reviewed the clinical record of the patient whose rights were alleged to have been violated. A site visit was conducted in February 2012, at which time the allegations were discussed with the Psychiatrist, a Staff Nurse, and the Director of the Mental Health Network, the Vice President of Patient Care Services and the Director of Corporate Compliance. The patient whose rights were alleged to have been violated was interviewed by telephone.

The HRA acknowledges the full cooperation of hospital personnel.

Findings

According to the patient whose rights were alleged to have been violated, he fainted in his kitchen and he was taken to the hospital via ambulance. The patient reported that he had taken Soma (pain management medication that combines aspirin, carisoprodol and codeine) per prescription for back pain. The patient stated that once at the hospital and after the toxicology reports were obtained, a psychiatrist talked to him saying that the patient had concocted a suicidal cocktail and that the patient needed to be admitted for behavioral health reasons. The patient adamantly denied being suicidal and believed he was held under a false claim.

In reviewing the clinical record, the patient arrived at the ED on February 13, 2011, at about 2:30 p.m. He was then transferred to the Intensive Care Unit around 4:00 p.m. that same day. The following day at about 10:30 a.m. he was transferred to the Neurology Department. He signed out Against Medical Advice that night at about 8:30 p.m. Thus, this investigation will include the entire time he spent at the hospital, not just the claim that the patient was unjustly held in the ED.

According to the clinical documentation, the patient was admitted to the hospital for an episode which occurred in his kitchen when he fell to the floor and began experiencing tremors that

lasted about five minutes. An ambulance was called; the paramedics noted dysarthria (slurred, slow speech, difficult to understand) and left upper extremity drifts. Documentation indicated that a brain attack evaluation referral was made before the patient arrived at the hospital.

The ED Physician noted that by the time the patient arrived to the hospital, he was already getting better in that he became awake, alert and he was oriented x 3 (by person, place and time). The admitting diagnosis was listed as CVA/TIA (Cerebral Vascular Accident/Tran ischemic attack). The patient was treated with charcoal; NPO (nothing by mouth) was ordered. Lab tests showed elevated salicylates and glucose, both were lowered during the hospitalization. The patient had a brain CT (Computerized Tomography) scan and a chest x-ray. No abnormalities were found on the CT scan and the chest x-ray was within normal limits. His ECG (Electrocardiogram) was also normal. Drug tests were positive for Benzodiazepine, Opiates and Ethanol.

On Monday (2/14/11) he had Neurology, Psychiatry and Pain Management consultations. In addition to follow-up lab tests, a brain MRI (Magnetic Resonance Imaging) and an EEG (Electroencephalogram) were completed; the MRI was unremarkable and the EEG was normal.

During the psychiatric evaluation, it was documented that the patient denied suicidal or homicidal ideation; he reported never having been hospitalized and he had never taken psychotropic medications. The patient was placed on suicide precautions (being observed by a one-on-one staff member) and an order was written at about 1:30 p.m. for the patient to be transferred for psychiatric services when he was medically cleared.

At the site visit the psychiatrist stated that he determined that the patient needed in-patient behavioral health services due to the possible overdose. He also stated that during the initial interview the patient was evasive, in that the patient would not readily answers his questions. He stated when he was able to discuss the patient's situation with the patient's wife, she collaborated the patient's assertion that he had accidentally taken more pain management medication than what was prescribed. The psychiatrist cleared the patient to be discharged home with his wife with follow-up in one week with a therapist. The patient subsequently signed out Against Medical Advice, meaning that he was leaving against the advice of the attending physician and of the facility administration. The record showed that the suicidal precautions were discontinued as well as the transfer to the behavioral health department.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 3-601 a, "When a person is asserted to be subject to involuntary admission on an inpatient basis and in such condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any person 18 years of age or older may present a petition…. The petition may be prepared by the facility director of the facility."

The patient was sent to the hospital for medical reasons which the hospital addressed during his stay. Once medically cleared, mental health services were recommended. The HRA acknowledges that the patient was overwhelmed with the thought of a possible mental health admission since he steadfastly denied that this service was necessary. However, the recommendation was not carried-out as the patient requested, a petition to authorize detention was not completed, and the HRA found nothing to support the claim that the patient was unjustly held at the hospital; the allegation is unsubstantiated.